

EXHIBIT 5

ECFMG RUSS 0000155

PART B

8 SECONDARY SCHOOL COLLEGE/ UNIVERSITY:	Schools Attended		Location (exact address)	Dates Attended (month and year)	No. School Years
	IMMACULATE CONCEPTION COLLEGE		BENIN CITY NIGERIA	JUNE 1974 SEPT 1979	5
9 MEDICAL SCHOOL: Use precise name and list all schools attended 690-010	Schools Attended		Location (exact address)	Dates Attended (month and year)	No. School Years
	UNIVERSITY OF IBADAN COLLEGE OF MEDICINE		IBADAN NIGERIA	JUNE 1982 JUNE 1987	5
9.1 CLINICAL CLERKSHIPS: Refers to that period of medical education in the clinical disciplines during which as a medical student you gained practical experience in hospitals or clinics. List clerkships (rotations, pre-graduate internships) for each clinical discipline.	Clinical Discipline	Hospital/Clinic	Location (exact address)	Supervising Physician	Dates of Clerkship
	MEDICINE	?		DR ONWUKA	MAR 1988 - JUNE 1988
	SURGERY	SPECIALIST		MR IDIAKHOA	SEPT 1988 - DEC 1988
	PAEDIATRICS	HOSPITAL	NIGERIA	DR ASEMOJA	DEC 1987 - MAR 1988
	OBSTETRICS	BENIN CITY		DR OJECIBA	JUNE 1988 - SEPT 1988
	GYNAECOLOGY				
If additional lines are necessary use the reverse side of Part C.					
9.2 MEDICAL DEGREE: Conferred or Expected	Title of Degree <u>MBBS</u> Date Conferred /Expected: <u>1987</u>				
10 MEDICAL LICENSURE: Present or Future	Date you received (or expect to receive) an unrestricted license or certificate of full registration to practice medicine: <u>YES</u> Country or state in which you are licensed: <u>NIGERIA</u>				
11 HOSPITAL TRAINING: Residency or fellowship	Hospitals	Position(s)	Dates		
11.1 EMPLOYMENT: Present employment only	Institution/Company		Position	Dates	
	Name: <u>MARY LAND MED. LABORATORY</u>		Phlebotomist	1992	
	Street: <u>1901 Sulphur Spring Road, Box 18290</u>				
	City/State/Country: <u>Baltimore MD 21227</u>				
12 BIRTHDATE/ BIRTHPLACE:	Day/Month/Year: <u>17-4-62</u> Location: <u>ILE-IFE, OSHUN, NIGERIA</u>				
13 SEX:	Please check one: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		14 NATIVE LANGUAGE: <u>YORUBA</u>		
15 CITIZENSHIP:	(Complete all three)				
	A. AT BIRTH		USA <input type="checkbox"/>	Other <input type="checkbox"/> (Specify) <u>NIGERIAN</u> <u>OS</u>	
	B. UPON ENTERING MEDICAL SCHOOL		USA <input type="checkbox"/>	Other <input type="checkbox"/> (Specify) <u>NIGERIAN</u>	
	C. NOW		USA <input type="checkbox"/>	Other <input type="checkbox"/> (Specify) <u>NIGERIAN</u>	

PART C

Students and graduates must sign the application in the presence of their Med. School Dean, Medical School Vice Dean, or Medical School Registrar. (See A below.)

If a graduate cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public (See B below) and must explain in writing why the application form could not be signed in the presence of a medical school official. (See B.1 below.)

Application forms are to be mailed to ECFMG from the office of the official or notary who witnesses the applicant's signature.

All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.



Seal, stamp or signature of official must cover a portion of the attached photograph.

16 CERTIFICATION BY APPLICANT

I hereby certify that the information given in this application is true and accurate to the best of my knowledge, and that the photographs enclosed are recent photographs of me.

I also certify and acknowledge that I have received the current edition of the ECFMG Information Booklet for FMGEMS and am aware of its contents.

I understand that (1) falsification of this application, or (2) the submission of any falsified educational documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or invalidate the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action.

I understand that the ECFMG certificate and any and all copies thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I hereby authorize the Educational Commission for Foreign Medical Graduates to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any Federal, State, or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

(Must be completed in English)

Signature of Applicant X *George*
(in Latin Characters)

16.1 CERTIFICATION BY MEDICAL SCHOOL OFFICIAL

A. I hereby certify that the photograph, signature, and information entered on this form accurately apply to the individual named above.

X _____
Signature of Medical School Official

OR

NOTARIZATION WITH EXPLANATION (Pertains to graduates only)

Official Title _____ Date _____ Institution _____
B. Subscribed and sworn to before me this 31 day of March, 19 92
X *Amelia R. Kishner* *Notary Public*
Signature of Consular Official, First Class Magistrate, Notary Public Official Title

B.1 Explain below why the application form could not be signed in the presence of your medical school dean, vice dean or registrar. Any explanation must be acceptable to ECFMG and must be provided each time you submit an application to ECFMG.

338/IID

RECEIVED

APR -6 1992

ECFMG

LEONARD J. KISHNER
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires September 2, 1994

482-700

17 Have you ever been denied licensure or authority to practice medicine by any medical licensing or registering authority, or has any such license or authority to practice medicine ever been suspended or revoked?

☐ Yes ☐ No

If the answer to this question is "Yes," please explain fully on a separate sheet of paper, giving details such as date, location, charge, and action taken; and provide any supporting documents.

ECFMG-000157

ECFMG_RUSS_0000157

TO BE USED AS CONTINUATION OF SECTION 9.1 IN PART B

11/15/19

ECFMG-000158

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